Health Care Financing

Abstracts of State Legislated Hospital Cost Containment Programs

Published by the Health Care Financing Administration
Office of Research, Demonstrations, and Statistics

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The Health Care Financing Administration (HCFA) was established in March 1977 to combine health financing and quality assurance programs into a single agency. HCFA is responsible for the Medicare program, Federal participation in the Medicaid program, the Professional Standards Review Organization program, and a variety of other health care quality assurance programs.

The mission of the Health Care Financing Administration is to promote the timely delivery of appropriate, quality health care to its beneficiaries—approximately 47 million of the nation's aged, disabled, and poor. The Agency must also ensure that program beneficiaries are aware of the services for which they are eligible, that those services are accessible and of high quality, and that Agency policies and actions promote efficiency and quality within the total health care delivery system.

HCFA's Office of Research, Demonstrations, and Statistics (ORDS) conducts studies and projects that demonstrate and evaluate optional reimbursement, coverage, eligibility, and management alternatives to the present Federal programs. ORDS also assesses the impact of HCFA programs on health care costs, program expenditures, beneficiary access to services, health care providers, and the health care industry. In addition, ORDS monitors national health care expenditures and prices and provides actuarial analyses on the costs of current HCFA programs as well as the impact of possible legislative or administrative changes in the programs.

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Contents

Foreword

This report presents a summary of State legislated efforts to control rising hospital costs. The abstracts which follow focus on legislated programs requiring the disclosure, review, or regulation of hospital rates and budgets. They represent the status of these efforts as of August 1980. The abstracts summarize key legislative features and operating aspects of each State program.

This updates the *Abstracts of State Legislated Hospital Cost Containment Programs*, originally published in 1978. Since the last publication, the number of States that have enacted legislation requiring the disclosure, review, or regulation of hospital rates or budgets has increased from 15 to 17. Florida, Illinois, and West Virginia have adopted legislation, while Colorado has repealed its legislation.

This report was compiled by the staff of the Hospital Rate Regulation Branch, Division of Hospital Experimentation, Office of Demonstrations and Evaluations, Office of Research, Demonstrations, and Statistics, Health Care Financing Administration. The staff of the Hospital Rate Regulation Branch includes Michael Hupfer (Branch Chief), Joseph Cramer, Charles De Furia, Albert Jones, and Stafford Sutton. A special thanks is due to Georgia Wells, the Branch secretary.

We also acknowledge those individuals in each State who have provided us with copies of legislation and pending bills.

Alfonso Esposito, Director
Division of Hospital Experimentation
Office of Research, Demonstrations,
and Statistics

Summary

As of August 1980, 17 States had legislation requiring the disclosure, review, or regulation of hospital rates or budgets. Those programs which require hospitals both to participate and comply with the results of a budget review or rate setting process are considered mandatory rate setting programs. There are currently eight mandatory State rate setting programs (Connecticut, Maryland, Massachusetts, New Jersey, New York, Rhode Island, Washington, and Wisconsin). In addition, Illinois is in the process of developing a rate setting program which would have mandatory authority if the Health Care Financing Administration approves the program for Medicare and Medicaid reimbursement on a demonstration basis. The remaining programs solicit voluntary compliance with the results of the review processes or operate simply as disclosure programs.

There is a substantial amount of diversity in these programs. Some systems relate to revenues, others to costs. Some systems involve individual budget review; others use formulas and screens. Some systems constrain the level of costs through penalties, others through screens or through the application of statistical standards. Some systems constrain the rates of increase in costs through global budget approaches, others by guaranteeing inflation increases but scrutinizing all other requests in detail.

Most of the programs are revenue-based and are concerned with the total financial needs of individual hospitals. The commission programs in particular attempt to limit the total revenue collected or received by a hospital to that hospital's total financial needs. This revenue limit is largely independent of whether or not payment rates are being set for all purchasers of health services. For instance, the Connecticut program only has direct control of charges. However, Connecticut hospitals must consider third party payer contractual allowances and the total amount of revenue expected from Blue Cross, Medicare, and Medicaid when setting their charges. In contrast, all payer rates are directly controlled by the Maryland Commission under a HCFA sponsored demonstration program. However, Maryland hospitals must still consider the discounts on charges granted to the Blue Cross, Medicare, and Medicaid programs by the Commission when setting their charges.

The cost based systems are primarily concerned with establishing a reasonable payment rate for a hospital, given the cost of delivering care in the hospital (where cost is defined according to a payer's principles) and in other comparable hospitals. The cost based systems are primarily Blue Cross and Medicaid prospective reimbursement programs using very similar definitions of hospital costs. However, these programs may apply to a total hospital budget as they do in Rhode Island. Further, if the payment unit is based on charges, the cost based system in effect limits total revenue, since charges must be set consistently for all payers.

A major distinction is often drawn between budget review systems and formula approaches to rate setting. But while hospital budgets continue to be the primary focus of most programs, the States have increasingly used formulas and statistical screens in their review procedures. In many cases, the characterization of a program as a budget review program only means that a budget submission is required. It does not imply how or whether the budget may be reviewed. Budget screening devices were originally conceived and used to standardize the review process and to pinpoint those areas within a hospital's budget that needed further detailed review. Washington's budget review program is the most frequently cited example of this screening process. Other budget review programs use statistical screens to eliminate the budget review entirely, provided an overall test of reasonableness is passed. That is, if a hospital's budget request is less than a specified rate of increase then the budget review would be suspended. In the Connecticut program, if a hospital's budget request does not pass an overall test of reasonableness, the budget is still not reviewed. The Connecticut program instead projects a reasonable budget for the hospital based on prior year budgets and costs. The Maryland system rarely involves any budget review. Maryland hospitals are guaranteed inflation increases which can be requested periodically. If a Maryland hospital needs more than an inflation increase, it may submit a budget and request a full review.

The payment methods used by rate setting programs have long been held to be extremely important because of the incentives they generate in hospitals. However, the review programs have substituted revenue control features which in many ways parallel the incentives which might be created by the payment methods themselves. In Connecticut, the total revenue budget approved for a hospital is controlled regardless of the payment unit. In Maryland, average revenue per diagnosis specific case or department specific average revenue per unit of service is controlled, and discounted charges are basically a method of apportioning costs to payers. However, there are new payment methods also being used by State programs. In New Jersey, payment rates for diagnosis specific cases are being set and paid by all payers. In Washington, one-third of the hospitals have been using a payment method which holds major third party payers responsible for an apportioned share of the hospital's total approved revenue budget.

The Office of Research, Demonstrations, and Statistics is sponsoring demonstration programs and funding developmental activities in several States. These efforts include demonstrations testing and the long term effects of all payer systems (Maryland), areawide budgeting (Rochester, New York), the effects of various payment methods and payer participation within a Commission review model (Washington), payment on a diagnosis specific per-admission basis (New Jersey), and research to develop a comprehensive data system and a case-mix adjusted per-admission based reimbursement system (New York).

The major characteristics of each of the 17 legislated programs are summarized in the following table.

TABLE 1
State Legislated Hospital Cost Containment Programs

State	Responsible Agency	Type of System	Voluntary vs. Mandatory	Payers Covered	Revenue Control Method	Unit of Payment	Frequency of Review	Adjustments	Appeals
Arizona	Department of Health Services; local HSAs	budget/rate review	mandatory review, voluntary compliance	charge-based, including Blue Cross	total revenue	charges	prior to any rate change	not applicable	not applicable
California	California Health Facilities Commission	disclosure	mandatory disclosure	not applicable	not applicable	not applicable	annually	not applicable	not applicable
Connecticut	Commission on Hospitals and Health Care	budget/rate review and approval	mandatory	charge-based	total revenue	charges	annually	retroactive volume; unforeseen and material change in expense	public hearing before Commission
Florida	State Insurance Department; Hospital Cost Containment Board	disclosure/ rate review	mandatory disclosure, voluntary compliance	not applicable	to be determined	to be determined	annually	not applicable	not applicable

TABLE 1 - Cont'd.
State Legislated Hospital Cost Containment Programs

State	Responsible Agency	Type of System	Voluntary vs. Mandatory	Payers Covered	Revenue Control Method	Unit of Payment	Frequency of Review	Adjustments	Appeals
Illinois	Illinois Health Finance Authority	budget/rate review and approval	mandatory	all payers	to be determined	to be determined	to be determined	to be determined	to be determined
Maine	Health Facilities Cost Review Board: voluntary budget review organization	budget/rate review	mandatory review, voluntary compliance	charge-based	total revenue	charges	annually	not applicable	not applicable
Maryland	Health Services Cost Review Commission	budget/rate review and approval	mandatory	all payers	total revenue; departmental revenue, guaranteed revenue per case, or maximum revenue per case	rate/based charges	as necessary	inflation, volume, cost beyond control	public hearing before Commission

TABLE 1 - Cont'd.
State Legislated Hospital Cost Containment Programs

State	Responsible Agency	Type of System	Voluntary vs. Mandatory	Payers Covered	Revenue Control Method	Unit of Payment	Frequency of Review	Adjustments	Appeals
Massa-chusetts	Massa-chusetts Rate Setting Commission	budget/rate review and approval	mandatory	charge-based	total revenue with cost limit	charges	annually	inflation, volume, cost beyond control	Division of Hearing Officers
		contract/cost/ rate review and approval	mandatory	Blue Cross	cost-based	routine per diem, ancillary charges	annually	Excess costs may be denied.	courts
		modified formula base	mandatory	Medicaid	cost-based with limits	per diem	annually	uncontrol-lable costs associated with change in government regulations	Division of Hearing Officers

TABLE 1 - Cont'd.
State Legislated Hospital Cost Containment Programs

State	Responsible Agency	Type of System	Voluntary vs. Mandatory	Payers Covered	Revenue Control Method	Unit of Payment	Frequency of Review	Adjustments	Appeals
Minnesota	Department of Health; Minnesota Hospital Association	budget/rate review	mandatory review, voluntary compliance	charge-based, including Blue Cross	total revenue	charges	annually and when requested during year	inflation, volume	Department of Health public hearing before independent hearing examiner; Minnesota Hospital Association-hearing before appeals panel

TABLE 1 - Cont'd.
State Legislated Hospital Cost Containment Programs

State	Responsible Agency	Type of System	Voluntary vs. Mandatory	Payers Covered	Revenue Control Method	Unit of Payment	Frequency of Review	Adjustments	Appeals
New Jersey	State Department of Health	budget/rate review and approval	mandatory	Medicaid and Blue Cross	cost-based	per diem	annually	retroactive for volume, economic factor, pass-through items	formal appeal before independent hearing officer
		budget/rate review and approval	mandatory	all payers	total revenue	cost per case and controlled charges	annually and when requested during the year	retroactive for volume, economic factor, pass-through items	formal appeal before Commission
New York	State Department of Health	rate setting	mandatory	Medicaid and Blue Cross	cost-based	per diem	annually	retroactive for actual economic factor and volume	formal appeal before State hearing officer
		charge control	mandatory	charge-based	charge increase	charges	as necessary	actual economic factor	Appeals Board

TABLE 1 - Cont'd.
State Legislated Hospital Cost Containment Programs

State	Responsible Agency	Type of System	Voluntary vs. Mandatory	Payers Covered	Revenue Control Method	Unit of Payment	Frequency of Review	Adjustments	Appeals
Oregon	State Health Planning and Development Agency	budget rate review	mandatory review, voluntary compliance	charge-based, including Blue Cross	total revenue	charges	annually and when requested during year	not applicable	not applicable
Rhode Island	State Budget Office; Blue Cross of Rhode Island	negotiated budget/rate review and approval	mandatory	Medicaid and Blue Cross	total expenses/ revenue	percent of charges	annually	retroactive volume	binding arbitration before independent mediation
Virginia	Virginia Health Services Cost Review Commission; voluntary cost review organization	budget/rate review	mandatory review, voluntary compliance	charge-based	departmental revenue	charges	annually	not applicable	not applicable

TABLE 1 - Cont'd.
State Legislated Hospital Cost Containment Programs

State	Responsible Agency	Type of System	Voluntary vs. Mandatory	Payers Covered	Revenue Control Method	Unit of Payment	Frequency of Review	Adjustments	Appeals
Washington	Washington State Hospital Commission	budget/rate review and approval	mandatory	all payers — all payers — charge based	Total revenue; rates per unit of service by revenue center	annual percent of total budget — percent of rate-based charges — charges	none — volume — volume	formal hearing before Commission or independent hearing officer	
West Virginia	Department of Health	disclosure/ rate review	mandatory disclosure, voluntary compliance	not applicable	not applicable	not applicable	annual disclosure; rate reviews as necessary	not applicable	
Wisconsin	State Department of Health; Rate Review Committee	budget/rate review and approval	mandatory	charge-based, including Blue Cross — Medicaid	total revenue	charges — per diem	prior to any rate change, one a year at most	none	hearing before independent appeals board

State: Arizona

Statute: Arizona Revised Statutes: Title 36, Chapter 4, Article 3, Title 36, Chapter 1, Article 1.1
Date: 1971 and amendments in subsequent years
Purpose: To review rates and charges, prescribe uniform accounting, and allow public disclosure of financial and statistical data for health care institutions
Responsible Agency: Department of Health Services and local HSAs

Regulations governing reporting requirements and procedures for hospital rate review are issued under the authority of the Department of Health Services. The local health systems agency and the State Department of Health Services both review and comment on proposed rate changes, but only the State Department of Health Services makes and issues the decision.

The HSA holds a public hearing, after which it decides whether or not to recommend approval. The Department of Health Services simultaneously conducts its own review. The Department considers, but is not bound by, the recommendation of the HSA. After its own review, the Department issues a statement as to whether the proposed rates are justified, and if not, what (if any) level of increase would be justified.
Facilities Covered: Mandatory participation but voluntary compliance by all non-Federal hospitals
Payers Covered: Charged-based payers (includes Blue Cross)
Current Program: The Department has implemented uniform accounting and annual reporting systems and publishes annual financial and statistical public disclosure reports. For any proposed change in charges, hospitals are required to file a notice with both the local HSA and the Department of Health Services at least 60 days prior to the implementation date. The hospitals may file for a change in charges at any time. In addition to a list of charges, the facility must supply cost and statistical data on its past, current, and prospective fiscal years.

Although the requirements for filing are standard, there are not statewide guidelines or methodologies for reviewing budgets or evaluating a proposed rate increase. Reviewers must determine whether the proposed rate of increase is reasonable based on the relevant quantitative and qualitative information submitted by the hospital under review. Some typical elements of the review follow: 1) determining if the profit level is reasonable (4 to 7 percent of gross patient revenue), 2) examining three-year trends in revenues and expenses, 3) checking the relationship between revenue and volume increases, and 4) analyzing three-year trends in patient mix, length of stay, and admissions.

The review may be conducted differently by the Department and the HSA. Additionally, the individual analysts may emphasize different areas in their reviews.

Primary factors considered in the reviews are inflation (salaries, supplies, and utilities), volume changes, and the total financial needs of the institution. Different hospitals may be compared for a particular cost center or area.

The local HSA must conduct a public hearing within 30 days and issue its findings within 60 days from the date of filing. Informal negotiations can occur during the review cycle. Hospital administrators may explain the material presented in the application. The Department of Health Services must issue its findings within 60 days of the date of filing, but the hospital need not comply, since compliance is voluntary. There are no fiscal risks nor retroactive adjustments in the system.

Hearings/Appeals: Since compliance is voluntary, there is no appeals mechanism. The State may conduct a public hearing to receive and review additional information and to resolve differences between the findings of the two review agencies. The hearings panel for the State is the Health Economics Committee of the Statewide Health Coordinating Council. While compliance is voluntary, the system requires public disclosure of unfavorable findings.

Developmental Activities: None

Pending Legislation: None

Contact for Additional Information:

Chief, Bureau of Health Economics
Division of Health Resources
Arizona Department of Health Services
1740 West Adams Street
Phoenix, Arizona 85007

State: California

Statute: Chapter 1242, Statutes of 1971, California Health Facilities Disclosure Act, as amended

Date: 1973

Purpose: To encourage economy and efficiency by enabling purchasers of care to make informed decisions and to facilitate comparisons of the performance of particular health facilities through public disclosure of health facility financial and statistical data

Responsible Agency: California Health Facilities Commission

The Commission consists of 15 members appointed by the Governor. Seven of the members represent the health care industry, and eight represent the public. The Commission has authority to require public disclosure of financial and statistical information by California health care facilities.

Facilities Covered: Mandatory accounting and reporting by all hospitals, skilled nursing facilities, and intermediate care facilities

Current Program: The Commission has established uniform accounting and reporting systems which must be used by hospitals, skilled nursing facilities, and intermediate care facilities in reporting their financial and statistical data. The Commission will be implementing the Annual Hospital Report (AHR) under a Federal grant. Also, a Uniform Hospital Data Discharge System is being tested at selected hospitals.

The Commission, under new authority, is setting expenditure estimates and efficiency standards for all hospitals for use in the health planning process.

Pending Legislation: Legislation to authorize the Commission to collect patient discharge data from hospitals is in the final approval stage. The legislation would also require quarterly reporting by hospitals of specific financial and statistical data for the validation of the voluntary effort. To date, the Commission has no authority for rate review or approval.
Contact for Additional Information:
Executive Director
California Health Facilities Commission
555 Capitol Mall, Room 525
Sacramento, California 95814

State: Connecticut

Statute: Public Act No. 73-117 Connecticut GSA 19-73a through 73q, as amended
Date: July 1973
Purpose: To create a Commission to improve efficiency, lower health care costs, coordinate use of facilities and services, and expand availability of health care throughout the State
Responsible Agency: Commission on Hospitals and Health Care

The Commission on Hospitals and Health Care consists of 17 members: three *ex-officio* (Commissioners of Health, Mental Health, and Insurance) and 14 appointed to represent the public and the industry (12 appointed by the Governor, one by the Speaker of the House, and one by the President *pro tempore* of the Senate). The Commission has direct authority to annually review and approve hospital operating and capital expenditure budgets. In addition, the Commission may, at its discretion, review the budgets of other non-governmental health care facilities and institutions. Further, the Commission grants Certificate-of-Need. The Governor appoints a full-time executive director who is responsible for the day-to-day operations of the Commission.
Facilities Covered: Mandatory participation and compliance by all non-governmental hospitals in budget and rate review; mandatory participation and compliance for all health care facilities and institutions in Certificate-of-Need review
Payers Covered: Charge-based payers directly and other payers indirectly through expense budget controls
Current Program: By July 3, hospitals are required to submit detailed cost, revenue, and statistical data for the past, current, and budget years, using a uniform reporting system. The budget year reviewed begins October 1.

The review process considers the overall financial requirements of the hospital to establish an approved net revenue figure. The process begins by applying an "overall reasonableness test" (ORT) screen or super screen to the hospital operating budget. To pass the super screen, the hospital budget must meet five conditions defined by State requlations. In essence, the net revenue and gross expenses for the budget year must not exceed the current year's net revenue (adusted for volume) by more

than the hospital's inflation factor plus 2 percent, and the hospital's forecasted price increase cannot exceed it's inflation factor. In addition, the Commission must be satisfied that the hospital meets the statutory criteria which the Commission must consider in reviewing budgets. A hospital's operating budget will be approved if it meets these conditions.

Hospitals which fail the ORT are subject to more detailed review and analysis. The Commission first evaluates the reasonableness of the hospital's projected expenses as follows: Hopitals are classified into peer groups. Within each peer group a hospital's base year (current year) costs are compared in three aggregations of cost centers: general services, routine services, and ancillary services. Units of services used to measure costs are adjusted patient days for general services, patient days for routine services, and adjusted discharges for ancillary services. If a hospital's cluster costs exceed 110 percent of the median for the group, the individual cost centers within the cluster are also screened. Within each cost center, any amount in excess of 110 percent of the median costs for the group are challenged.

Reasonable base year costs are then adjusted for inflation, volume, and non-volume changes to establish reasonable, prospective, budget year expenses. The inflation factor is a composite index to predict the impact of inflation on the cost of hospital services. This index is based on proxies of actual hospital expense categories which are external, but comparable, to the hospital industry. Certain types of expenses, such as depreciation, interest, malpractice costs, and physicians' salaries, are individually evaluated. Expenses due to volume are assumed to be 50 percent variable. Non-volume changes consist primarily of new or expanded services. The adjusted budget year expenses are then compared to the requested budget year expenses. The operation expense budget base becomes the lower of the two.

In addition to the operating expense budget, the Commission also considers required working capital, bad debts, and other financial requirements. The Commission then orders a net revenue budget and a capital expenditures budget for the hospital. The hospital's net revenue budget is translated into a schedule of charges.

The facility is at risk for all revenues or expenses in excess of the approved level (adjusted for volume). Any excess revenue is applied to the next year's financial requirements.

The only retroactive adjustment is for changes from budget volume. The facility may request an adjustment during the year, however, to meet unforeseen and material change in expenses.

Hearings/Appeals: The facility may informally review its requested budget with the Commission and attempt to work out a proposed negotiated settlement during its budget process. If the hospital disagrees with the initial Commission decision, it may request a public hearing of record before a panel of three Commissioners. Having heard the facility's position, the panel makes a formal report and recommendation to the full Commission. The facility may address the report to the full Commission before the Commission makes a decision.

Developmental Activities: Under HCFA Contract No. 600-76-0172, the Commission is developing new methodologies to be incorporated into the budget review system. These include: further refinement of the inflation factor, more sophisticated volume adjustments for fixed and variable costs, and improved grouping and productivity screens.
Pending Legislation: None
Contact for Additional Information:
Executive Director
Commission on Hospital and Health Care
340 Capitol Avenue
Hartford, CT 06115

State: Florida

Statute: Florida Statutes, Chapter 395, Part II, Section 395.501-395.514
Date: 1979
Purpose: To encourage economy and efficiency by enabling purchasers of care to make informed decisions by publicly disclosing health facility costs; to ensure that charges are reasonable by initiating reviews.
Responsible Agency: State Insurance Department; Hospital Cost Containment Board

The 1979 Florida Legislature enacted a law giving the State Insurance Commissioner the power to review individual hospital budgets and specify a uniform system of financial reporting for hospitals, based on a uniform chart of accounts. The legislation establishes a nine member Hospital Cost Containment Board within the State Insurance Department, composed of three major health care purchasers (including at least two from the health insurance industry), three providers (including at least two hospital Administrators), and three consumers (including at least one representing the elderly). The Insurance Commissioner, the President of the Senate, and Speaker of the House of Representatives are each to make one appointment from each of three categories.
Facilities Covered: Mandatory participation but voluntary compliance by all hospitals
Current Program: The Florida program is still in the developmental stage. The Board is empowered to require the submission of hospital financial and accounting data (other than information relating to the costs of physician services, which are billed independently) and has specified a uniform system of financial reporting. The legislation specifically prohibits the Board from adopting a uniform accounting system. Training sessions are being conducted to familiarize the hospitals with the reporting requirements.

The Board may initiate reviews of hospitals budgets, projected annual revenues, and the rates and charges proposed to generate those revenues. The Board plans to use a budget screening methodology in the future. If a hospital's rates and charges or other statistical indicators (such as percentage increase in rates over the preceding year) are in the upper 20 percent of such indicators for a comparative group of hospitals, the

Board is authorized to review the budget at a public hearing. The findings of any such hearing would be published in the largest general circulation newspaper in the county in which the hospital is located.

The Board is also required to annually publish an "in-depth study comparing the rates and charges and other relevant information of all hospitals, both statewide and by county" (Florida Statutes).

There is no appeals system since compliance is voluntary.

Developmental Activities: None

Pending Legislation: None

Contact for Additional Information:

Information Officer
Hospital Cost Containment Board
Department of Insurance
B-5 Larson Building
Talahassee, Florida, 32301

State: Illinois

Statute: Public Act 80-1427

Date: 1978

Purpose: To establish an equitable and manageable system of prospective payment for hospital services that ensures equity to payers, and assesses the financial requirements and viability of hospitals for the efficient delivery of health care

Responsible Agency: Illinois Health Finance Authority

In 1978, the Illinois Legislature enacted Public Act 80-1427, establishing the Illinois Health Finance Authority (IHFA), with five voting and five non-voting members. The five voting members, no more than three of whom may be from the same political party, are four public members and one hospital trustee. The Director of Public Aid serves as an ex-officio, non-voting member. The other four non-voting members must be two hospital administrators and two representatives of third party payers.

The IHFA has a full-time professional staff to develop the prospective payment system. The IHFA is financed through an annual fee, up to a maximum of 0.1 percent of a hospital's annual operating budget.

Facilities Covered: Mandatory participation and compliance by all non-Federal hospitals

Payers Covered: All payers must be covered for the system to be implemented

Current Program: The Illinois prospective payment system is in the developmental stage. IHFA members have been appointed and are working toward defining the system. The IHFA has adopted four principles to which the system must adhere. (1) The IHFA should define and promulgate simple standards of reasonableness to give the hospital industry adequate notice of the basis upon which rates will be reviewed. (2) The hospital should be held accountable for costs within its control and not held accountable for costs which are beyond its control. (3) Hospital boards, medical staffs, and management should be given as much prerogative as possible over the financial management of their

hospitals. (4) Hospital cost containment should be achieved through the introduction of appropriate incentives in the health care financing system rather than through penalties and sanctions.

Rate setting will take place using one of two methodological tracks: an "incentive rate track" or a "budget review track." Each track will adjust a hospital's revenue base by factors for inflation (an economic factor), intensity, and volume, as well as certificate of need, fixed and operating costs, and other elements of financial requirements. The additional elements include working capital, bad debts, charity care, research, and education. The tracks are differentiated by the manner in which the rate is determined, but both will establish a gross revenue cap. The incentive track will establish a hospital's presumptively reasonable costs and build the revenue limit without recourse to detailed cost comparisons or negotiation. The budget review track will require a detailed review of projected expenditures and comparison with peer hospitals. The hospital will choose the track. The incentive rate, derived from the incentive rate track, will actually be calculated by the hospital using the IHFA's uniform financial report and the adjusting factors mentioned above.

The IHFA is required to develop a uniform system of financial reporting. In the field of health planning, it must abide by the determinations of the Illinois Health Facilities Planning Board and is specifically prohibited from performing health planning functions itself.

The IHFA must approve hospital rates on a prospective basis. All hospitals, purchasers, and third party payers must recognize and accept the approved rates as payment in full. The IHFA must assure purchasers and payers that a hospital's rates are reasonably related to its financial requirements and that the rates apply equitably to all purchasers of care without unfair discrimination.

The IHFA must set an effective date for each hospital. After the effective date (which may not start less than six months after the IHFA adopts a uniform reporting system or less than four months after each State agency and major Federal health program agrees to participate), any changes in hospital rates must be approved. Hospitals seeking a rate change must submit the proposed change to the IHFA at least 90 days prior to the proposed effective date. If the IHFA does not act within 60 days, the rates are deemed approved. If a hospital has not filed sufficient data to evaluate the changes, the 60 day period is held in abeyance. Hospitals have 15 days to request reconsideration of a rate. If the IHFA does not act on the appeal request within 15 days, the request in considered denied.

All major public payers—that is, Medicaid and Medicare—must agree to pay the rates set by the IHFA before the rate setting function may begin.

The legislation specifies that a hospital may keep any surplus which it is able to achieve within the approved rate. It must also bear any deficits which it incurs in excess of the approved rates.

A date for beginning the rate setting system has not yet been established. The legislation has a sunset date of October 1, 1982.

Developmental Activities: See current program above.
Pending Legislation: None
Contact for Additional Information:
Executive Director
Illinois Health Finance Authority
524 South Second Street
Room 577
Springfield, Illinois 62706

State: Maine

Statute: Sec. 1.22 MRSA Chapter 105, Health Facilities Information Disclosure Act
Date: April 1978
Purpose: To establish uniform systems of reporting health care information and to provide for review and comment on proposed budgets of any hospital
Responsible Agency: Health Facilities Cost Review Board or approved voluntary budget review organization

The Health Facilities Cost Review Board consists of 10 members, eight of whom are appointed by the Governor. Five members are consumer representatives and three are industry or provider representatives. In addition, the Commissioner of Human Services or his/her designee will serve as an ex-officio voting member, and the Superintendent of Insurance or his/her designee will serve as an ex-officio non-voting member. The Board has designated the Voluntary Budget Review Organization (VBRO) as the organization approved to carry out the budget review provisions of this act.
Facilities Covered: Mandatory participation but voluntary compliance by all non-Federal hospitals
Current Program: Hospitals are required to annually submit a prospective budget to the Board or a VBRO 90 days prior to their new budget year. The budget submission is reviewed for clerical accuracy and completeness. Then various reference values are automatically calculated for budget analysis and for future comparative reports which will be distributed to member hospitals.

Similar hospitals have been classified into peer groups to permit comparisons of reference values (screen and explanatory variables) during the budget review process.

Each calendar quarter, the VBRO publishes a percent change target (PCT) based on an economic projection of the inflation rate. The hospital's percent change (budget year over current year) in total operating revenue per adjusted admission is compared to the predetermined PCT.

Budgets that are within ± 10 percent of the PCT are then subject to the revenue screen, which is based upon the lowest quartile value of the peer group for net patient revenue per adjusted admission. If the hospital's value is equal to or less than the peer group value, no further analysis is performed.

If the budget does not meet the PCT test, or if it fails the revenue screen, it is subjected to an expense screen which is based upon the median value of the peer group for total operating expense per adjusted admission. If the hospital's value is greater than the peer group value, a detail budget review is undertaken.

If a hospital is not included in a peer group because of unique characteristics, or if the budget failed the expense screen, it is subjected to a detailed analysis to determine the reasonableness of the budgeted operating expenses.

If the budget passed the expense screen, or if a detailed review was required, the budgeted operating margin (other financial requirements) is reviewed for reasonableness. When analysis of the proposed budget is finished, findings are prepared in draft as a staff report.

The draft is reviewed with the hospital for accuracy of the findings and to obtain the hospital's comments.

The finalized staff report is sent to the hospital and members of the Hospital Budget Review Panel approximately 15 days before the panel is to meet on the hospital's budget submission. Approximately 30 days before the beginning of the budget period, the panel reviews the budget submission for reasonableness. All panel meetings are closed; however, the hospital is invited to attend to answer questions or to provide additional information.

The Hospital Budget Review Panel, after completion of its review and meeting with the hospital, prepares and issues a letter setting forth its opinion as to the reasonableness of the proposed budget. This letter is sent to the hospital within three days of the meeting. A copy is sent to the Health Facilities Cost Review Board (State Board) within 30 days of the review meeting.

Developmental Activities: None

Pending Legislation: None

Contact for additional Information:

President
Voluntary Budget Review Organization of Maine
One Memorial Circle, Box 8
Augusta, Maine 04330

State: Maryland

Statute: Article 43, Section 568H through 568Y, Annotated Code of Maryland

Date: July 1973, with subsequent amendments

Purpose: To make public the financial positions of hospitals and related institutions, to assure all purchasers of hospital services that costs are reasonably related to services offered, and to establish equitable rates for all purchasers of services

Responsible Agency: Health Services Cost Review Commission

The Health Services Cost Review Commission is a seven member independent commission appointed by the Governor. A majority of the Commission must not have any connection with the management or policy development of any hospital or related institution.

Prospective rates are developed by a full time professional staff operating under regulations issued by the Commission. In addition to promulgating reimbursement rates, the Commission has the authority to hold public hearings, conduct investigations, and require the submission of data relevant to the cost of hospital services.

Facilities Covered: Mandatory participation and compliance by all non-Federal acute short-term general hospitals and all non-governmental long-term and specialty hospitals

Payers Covered: All purchasers of hospital services (Medicare and Medicaid on an experimental basis)

Current Program: The Maryland rate setting system uses a quasi-public utility approach to hospital rate regulation, in which rates are set and then adjusted for such items as inflation, volume changes, and pass-through costs. Hospital rate setting in Maryland currently consists of three systems: rate review, inflation adjustment, and the Guaranteed Inpatient Revenue System (explained below).

A rate review system is used to develop an initial set of rates approved for units of service in the various revenue producing departments. Under this system, all hospitals are required to annually submit data on base and budgeted years, using a uniform accounting and reporting system. The total approved revenues are based on four component parts: direct and allocated indirect departmental expenses, other financial considerations (inclusion of bad debt, charity, and working capital), a payer differential, and a capital facilities allowance for buildings and equipment. The capital facilities allowance is used in place of historical cost depreciation to allow hospitals to be paid for equipment use at a level which allows replacement at current market prices. It also provides for a downpayment for buildings at 20 percent of current market prices for those hospitals which are effectively used or at the hospital's mortgage payment, whichever is higher. This system is applied relatively infrequently since most hospitals now receive rate increases under the Inflation Adjustment System. However, the hospital can request a new list of rates under the rate review system.

The Inflation Adjustment System was instituted to allow hospitals reasonable rate increases while avoiding the administrative burden of full rate review. It considers inflation adjustments, volume adjustments, changes in payer and case mixes, and certain pass-through costs.

Inflation adjustments are made for: 1) salaries and fringe benefits and 2) food, supplies, utilities, and other expenses. The inflation adjustment system has three components. First, the retroactive provision compensates the hospital for the past year if actual inflation was greater than the projected rate. (Conversely, if the actual rate is lower than the projected rate, then a deduction will be made in the budget year rate.) Second, if a correction needs to be made, a price leveling adjustment brings the rates to the level where they would have been if the inflation rate had been projected accurately. Finally, the provision for future inflation is established at a level equal to the most recent changes in inflation.

Volume for the budget year is established at a level equal to the actual volume for the current year. Different fixed-variable cost proportions have been established for the routine and ancillary areas as, well as for different magnitudes of volume changes.

Pass-through costs are limited to: 1) changes in the Federal minimum wage law to the extent that they exceed wage and salary allowances, 2) actuarially-supported pension cost increases (only to the extent that such increases were above the allowed increase for inflation), and 3) incremental costs resulting from compliance with requirements mandated by the Commission.

The Commission instituted the Guaranteed Inpatient Revenue (GIR) System because of concern that the present system, based on rates per units of service, was leading to increased volume and over use of hospital services. The GIR system, being tested in 16 hospitals, seeks to control the volume of ancillaries and lengths of stay. It guarantees payment for each case treated by the hospital. The GIR system determines the average charge for each diagnosis for each type of payer. The average charge is adjusted for inflation and a 1 percent factor for growth and technology. The total GIR payment is the product of discharges (by diagnosis and payer) and adjusted charges. At year end, the GIR payment is compared to the revenue from the Commission-approved rates charged by the hospital during the year. If the revenue from rates is less than the GIR payment, the hospitals will receive the fixed cost portion of the savings. However, if the revenues exceed the GIR payment, the Commission will recoup the additional funds from the hospital in the following year.

Hearings/Appeals: If the facility is not satisfied with its initial rates, it may request a detailed budget review. If dissatisfied with the outcome of the budget review, it may request a hearing before the Commissioners. If still dissatisfied with the decision of the Commissioners, its recourse is to the courts.

Developmental Activities: Under HCFA Contract No. 600-76-0140, the Commission is refining methodology to adjust for case-mix, reviewing the economic impact of State hospital regulations, and establishing a statewide policy to deal with charity care.

Pending Legislation: Legislation is currently pending which would finance the Commission by taxing hospitals directly.

Contact for Additional Information:

Executive Director
Health Services Cost Review Commission
201 West Preston Street
First Floor
Baltimore, Maryland 21201

State: Massachusetts

Statute: Blue Cross: MLG c. 176A, s. 5
Public Assistance (including Medicaid): MGL c. 6A, ss. 31–36
Charge Payers: Chapter 409 of the Acts of 1976
Date: 1976
Purpose: To establish fair, reasonable, and adequate rates and to reorganize in an equitable and feasible manner the health care delivery system of Massachusetts
Responsible Agency: Massachusetts Rate Setting Commission

The Massachusetts Rate Setting Commission consists of three Commissioners and a full time professional staff. The staff is supported by an Advisory Council, consisting of representatives from the public and the health care industry. In addition, a Hospital Policy Review Board oversees activities related to hospital charge and budget reviews. This group's authority is limited to review and comment on proposed rules and regulations.

Facilities Covered: Mandatory participation and compliance by all non-Federal hospitals

Payers Covered: Charge-based payers. Rates are also set separately for Medicaid, using a prospective methodology. The Commission approves the Blue Cross contract with hospitals and conducts Blue Cross and Medicaid audits.

Current Program: The Massachusetts Commission is unique in that it uses different methodologies to determine the reimbursement rates for different payers.

Medicaid

The Medicaid prospective rate system is a formula system that sets an inpatient *per diem* rate. Hospitals are required to annually submit historical costs using uniform reporting. A two-year base is used in the prospective rate system, and base year costs cannot exceed cost of the prior year by more than an approved inflation index. Base year costs are determined by Medicare definitions of allowable cost and are verified with audited data. The base year costs are indexed forward to the budgeted year by applying a weighted average inflation factor. The weights for various cost categories are derived from hospital data multiplied by published and forecasted inflation indicators. The same inflation factor is applied to each hospital. Budgeted costs in excess of the inflation indexed costs are disallowed, with the exception of items beyond the control of management (for example, FICA) and new costs associated with major capital expenditures approved through the Certificate of Need program.

The inpatient *per diem* rate is computed by dividing total base year allowable inpatient costs by total allowable base year inpatient days. This amount is inflated according to the index described above. Volume adjustments, with the exception of minimum occupancy levels, are recognized only through changes in the volume of patient days. Minimum occupancy levels vary according to type of service and type of hospital (teaching or non-teaching). In addition, routine costs (bed and board) are subject to Medicare routine *per diem* limitations.

While there are no retroactive adjustments, administrative adjustments for uncontrollable costs are permitted during the year. The facility is at risk for any overexpenditure.

Charge Payers

Under Chapter 409, hospitals are required to annually submit past, current, and prospective year costs so the Commission can review individual budgets. The hospital submits these budgets to the Commission 60 days before the beginning of its fiscal year. The Commission has adopted a uniform reporting manual which is very similar to the System for Hospital Uniform Reporting (SHUR), so hospitals report cost and statistical data in a uniform manner. In general, the approval process determines reasonable financial requirements for a hospital and then approves a set of charges to cover them. In October 1978, the Commission adopted a definition of "total patient care cost" which reflects the reasonable financial requirements of an individual hospital for providing patient care. The requirement comprise three parts: (1) operating requirements, (2) capital requirements, and (3) working capital requirements.

To determine the operating requirement for the budget year, base year costs are adjusted for inflation, volume, costs beyond control, and new services. Two inflation indices, each using a different number of cost categories, have been developed. The individual hospital chooses its index. The cost categories are paired with an economic change indicator. Prior to the start of each hospital's fiscal year, the Commission projects values for the rate of increase in each indicator. The Commission also develops a separate index for each category for the intermediate and budget years. The inflation factors for the intermediate year are based on both actual data and projections, while the budget year index is forecasted. The base year costs in each category are indexed forward to the budget year.

The second major adjustment is for changes in volume. Hospitals receive marginal cost adjustments calculated as direct costs using a 60:40 fixed/variable split without corridors. The volume statistics are overhead-adjusted patient days, routine-patient days, ancillaries-departmental statistics, and outpatient-visits.

The operating requirement for the budget year is adjusted for two other factors: costs beyond control and new services. Costs beyond control are cost increases which are "beyond the reasonable control of the individual hospital" and are not adjusted by inflation and changes in volume. These costs are added to the intermediate and budget year operating costs. New services, which are defined as new cost centers, are approved as part of the budget year operating costs if they meet planning approval and if the net patient revenue from the new service is less than or equal to the reasonable financial requirements of the new services.

The other reasonable financial requirements are the capital and working capital requirements which, together with the hospital's operating requirement, yield the total reasonable financial requirements for a hospital. The capital requirements consist of 1) building, fixed

equipment, and major movable equipment historical cost depreciation for the budget year, 2) interest expense for the budget year, and 3) the return on investment for proprietary hospitals. The working capital requirement is an allowance sufficient to finance the increase in accounts receivable due to inflation, taking into account the expected growth in accounts payable.

In July 1980, interim provisions to the charge control act were enacted which placed an 11½ percent inflation cap on charge increases for fiscal year 1981. The cap incorporates a voluntary review by regional hospital councils to comply with the inflation cap on a regional basis, if the overall cap is exceeded at the State level. This voluntary review is backed up by the authority of the Commission to adjust hospital charge increases in those instances where the voluntary rule is not effective.

Blue Cross

The Commission reviews and approves proposed contracts between Blue Cross and hospitals and rates developed under those contracts.

The Commission staff retrospectively reviews and audits facilities' cost reports using a uniform cost report system for Blue Cross and Medicaid. In addition to the audit of rate year costs, those costs are compared to the prior year to analyze incremental cost increases, volume changes, and items beyond management control (FICA and malpractice, for example) unique to each facility. Any amount in excess of costs may be denied the facility. The Commission is currently working with Blue Cross to tighten the limits on allowable annual increases in cost and to perform cost comparisons to determine reasonable Blue Cross rates. The facility does, under the Blue Cross contract, have the opportunity to justify any unusual expenses. Blue Cross pays a *per diem* rate for routine costs and charges for ancillary services.

Hearings/Appeals: Facilities have the right to appeal non-Blue Cross decisions of the Commission, under the State's administrative procedures act, to the Division of Hearing Officers. If dissatisfied with the outcome at that level, they have recourse to the courts. Blue Cross decisions can be appealed directly to the courts.

Developmental Activities: Under Federal Contract HCFA No. 600-76-0174, the Commission has developed a uniform data base and cost reporting system, more precise cost definitions, departmental inflation indices, methods of volume and case-mix adjustments, and inter-institutional base year cost comparisons. The base year cost comparisons will be implemented for fiscal year 1980 reviews so, when fiscal year 1981 reviews are conducted, the cost comparisons will become a permanent component of the budget approval program.

Pending Legislation: Interim legislation to amend the charge control (Chapter 409) program was passed in July 1980 for fiscal year 1981 only.
Contact for Additional Information:
Chairperson
The Commonwealth of Massachusetts
Rate Setting Commission
One Ashburton Place
Boston, MA 02108

State: Minnesota

Statute: Minnesota Statutes Section 144.695 through 144.703
Date: 1976
Purpose: To assure all purchasers of hospital services that the total costs of a hospital are reasonably related to the total services offered, that the hospital's aggregate revenues as expressed by rates are reasonably related to the hospital's aggregate costs, and that rates are set equitably among payers
Responsible Agency: Department of Health, other approved non-profit agency

The Commissioner of Health establishes rules and regulations governing the Department's review of hospital budgets and reviews and comments on the reasonableness of the hospital rates. In addition, the Commissioner may certify a program of budget review and comment operated by a non-profit corporation whose systems and procedures are substantially equivalent to those adopted by the Commission. Hospitals may choose to be reviewed by the State or any of the certified alternative programs. The Minnesota Hospital Association (MHA) has been so designated, and all but the State hospitals submit their rates for review to the Association.
Facilities Covered: Mandatory participation but voluntary compliance by all non-Federal hospitals
Payers Covered: Charge-based payers (includes Blue Cross)
Current Program: Hospitals are required to submit cost and statistical data for past, current, and prospective budget years before the beginning of their fiscal year and at least 60 days before any rate changes go into effect. There is no uniform accounting and reporting system.

The MHA conducts a budget-rate review process to determine problem areas which should be examined by review panels. The review process includes an initial desk audit, peer group screens, and an examination of the prospective year's overall expense percentage increase over the current year's projected expenses. Peer groupings are established by the State through a cluster analysis which considers the following: geographic location, service index based on presence or absence of type of service, percent of surgery to total admissions, percents of Medicaid and Medicare admissions to total admissions, and level of teaching activity. Within groups, hospital costs are analyzed for variance from the average cost per adjusted admission. The other peer group screens compare the budget year expenses in 15 functional cost categories to the peer group means. The hospital must explain any variances from peer group means.

The MHA convenes review panels, consisting of three hospital representatives, two third-party payer representatives, and two consumer representatives. These panels are ultimately responsible for reviewing and commenting on hospital rate requests. Rates must be sufficient to supply the financial resources necessary to meet the hospital's financial requirements.

The State and the MHA determine inflation adjustment in this rate review process. The MHA uses the Delphi panel method. This method requests eight or nine local businessmen, in medically related industries, to assess the expected price increases in each cost category. The staff then averages the respondents' projections for each cost category to determine that category's inflation factor. The State estimates inflation using monthly forecasts from Data Resources, Inc.

Depreciation is indexed forward from historical cost to reflect the impact of inflation, and the need for replacement beds is considered.

In addition to analysis of the operating budget, the capital expenditure budget and projected working capital needs are reviewed to establish the overall reasonable financial needs of the facility. There are retroactive adjustments based on changes in volume and inflation indices. A facility may also request an interim adjustment at any time during the year.

There are no direct incentives or risks because there is voluntary compliance. However, the Blue Cross contract limits reimbursement to approved rates. A compliance review is performed. Revenues in excess of financial needs must be applied against next year's needs, unless the hospital can demonstrate that the revenues were generated through productivity gains. Justified losses may also be offset in next year's revenue.

Hearings/Appeals: The system of hearings and appeals is different for hospitals reviewed by the hospital association and hospitals reviewed by the State.

Minnesota Hospital Association

After informal discussions are held between staff and the facilities, a seven member review panel (four consumer members, three provider members) examines and rules on all issues. If the facility is dissatisfied with the ruling, it may request another hearing before an appeals panel.

Department of Health

If points of difference cannot be resolved by informal discussions between staff and the facility, a public hearing is held, presided over by an independent hearing examiner. The findings of the hearing examiner are reviewed by the Commissioner of Health. The final decision is made by the Commissioner, with the advice and consent of the Attorney General.

Developmental Activities: Work is currently being done to refine both the grouping techniques and the methodology for developing the inflation factor. A cost estimating model is being considered in lieu of inter-hospital comparisons.

Pending Legislation: None
Contact for Additional Information:
Director of Rate Review
Minnesota Department of Health
717 Delaware Street, S.E.
Minneapolis, Minnesota 55440

Director, Rate Review
Minnesota Hospital Association
2333 University Avenue, S:E.
Minneapolis, Minnesota 55414

State: New Jersey

Statute: New Jersey Health Care Facilities Planning Act, P.L. 1971, Chapter 136 and; 1978 Amendments (Senate Bill 446), P.L. 1978, Chapter 83
Date: 1971 and 1978
Purpose: To ensure hospital and related health care services of the highest quality, and to ensure that they are efficiently provided and properly utilized at a reasonable cost

Since 1976, a hospital rate setting program called the SHARE (Standard Hospital Accounting and Rate Evaluation) system has been operated by the State of New Jersey. On January 1, 1980, a new State payment system, authorized by the passage of State Bill 446 and based on patient case-mix, was implemented in 26 hospitals. Over the next two years, all hospitals will be phased into the S.446 system. Forty hospitals will join the case-mix payment program in 1981, and 43 will be added in 1982.

Responsible Agency:

SHARE System: New Jersey State Department of Health

Prospective rates are developed by the staff of the Department of Health under regulations promulgated by the Health Care Administration Board and issued by the Commissioner of Health. The Health Care Financing Administration Board consists of the Commissioners of Health and Insurance (ex-officio) plus 11 additional members appointed by the Governor and confirmed by the State Senate, representing both the public and the hospital industry.

S.446 Case-Mix System: New Jersey State Department of Health

The new legislation creates a five member New Jersey Hospital Rate Setting Commission to approve or adjust hospital rates proposed by the Commissioner of Health. The Commission is an independent organization established within the State Department of Health. The Commissioners of Health and Insurance serve on the Commission ex-officio. Two consumer representatives and one representative experienced in hospital administration or finance are appointed by the Governor, with the advice and consent of the Senate. The Commission selects its own executive secretary with additional staff provided by the Department of Health. Decisions of the Commission are effected by a majority vote of the full membership.

Facilities Covered:

SHARE System

Mandatory participation and compliance by all short-term acute and non-State specialty hospitals

S.446 Case-Mix System

Mandatory participation and compliance by 26 short-term acute hospitals; by 1982, mandatory participation by all short-term acute hospitals

Payers Covered:

SHARE System

Blue Cross, Medicaid, and other State governmental purchasers of hospital and related health care services

S.446 Case-Mix System

All purchasers of hospital and related health care services (including Medicare and Medicaid on an experimental basis)

Current Program:

SHARE System

Hospitals are required to file an annual uniform report containing actual cost data and patient volume statistics.

Hospitals have been given the option of budget review or acceptance of a calculated global rate under the SHARE program. Hospitals accepting the global rate avoid budget review. The global rate is determined by increasing the previous year's approved budget by an economic factor reflecting inflation and the hospital intensity increase and then dividing this total by budgeted patient days.

Hospitals who do not accept the global rate enter the budget review system. The review consists of two types on screens: cluster and departmental. Ancillary, general service, and inpatient care clusters are formed from the hospital normal, functionally-reported cost centers and submitted to a screen, 110 percent of the most recent year's actual costs (for example, 1978 actual for 1980 rates). For those clusters not passing the screen, the individual cost centers within the cluster are further screened by a percentage of the median cost for an appropriate grouping of hospitals depending on the cost center. Hospitals are usually allowed up to 110 percent of the median cost to pass the screen. In some cases, screens are 20 percent to 50 percent above the median.

The appropriate type of grouping varies according to the cost center. A hospital type grouping consists of seven categories: major teaching, other teaching, large, medium, or small general short-term acute hospitals, rehabilitation centers, and specialized care facilities. An area character grouping consists of four geographic distinctions: inner city, urban, suburban, and rural. A statewide grouping is also used.

Following the screening process, adjustments are made for inflation, volume changes, legally mandated changes, and approved new management projects to determine a preliminary prospective budget. A proposed alternate rate (PAR) is then sent to the hospital. The hospital has 60 days to meet with the department analysts to complete an administrative appeal regarding the PAR. The rate analyst must then meet with the hospital administrator on the appeal. After consideration of the hospital's explanation, original disallowances can be restored if

justified, and an alternate payment rate is set. Expenses in certain cost centers—malpractice, utilities, plant depreciation, facility interest, and legally mandated fringe benefits—are adjusted for actual expenditures (pass-through items).

The approved budget is divided by the budgeted patient days to determine the *per diem* for the budget year. The facility is at risk for all overexpenditures, with the approved *per diem* serving as a ceiling for the obligation of Blue Cross and Medicaid. However, retrospective adjustments are made for changes in volume, actual economic factor experience, and the pass-through items mentioned above.

S.446 Case-Mix System

In 1976, the Department of Health, Education, and Welfare (now Health and Human Services) contracted with the New Jersey Department of Health to develop a hospital prospective rate setting experiment based on patient case-mix. In 1978, the New Jersey Legislature enacted Senate Bill 446, authorizing the establishment of a new hospital payment system applying to all purchasers of hospital and related health services. The new rate setting system employs the case-mix methodology designed by the State as part of the HCFA developmental contract.

The S.446 Case-Mix System establishes a per case rate of payment specific to each type of patient. The key to this process is the DRG (Diagnosis Related Group) patient classification method—a technique for categorizing hospital inpatients into 383 diagnostic groups that are both medically meaningful and similar in consumption of hospital resources. The 383 DRGs were derived through a statistical analysis of New Jersey hospital inpatient discharges, using an interactive physician-computer method (AUTOGRP, developed at Yale University).

Setting rates per case begins with collecting, processing, and linking three data sets for the base year. The base year is the second prior year before the rate year (for example, 1978 is the base year for the rate year 1980), and the data sets are medical discharge abstracts, patient billing records, and hospital financial and statistical uniform reports.

The medical discharge abstract is linked to the patient billing record for the same patient. Each patient is assigned to a DRG according to five classification variables: principal and secondary diagnosis, principal and secondary operative procedures, and age.

Financial and statistical data for the base year come from the SHARE system reporting forms. Cost centers are clustered into direct patient care costs, indirect or institutional costs, and general service costs categories. General service costs (medical records, dietary, housekeeping, laundry and linen, central and sterile supply, and non-drug pharmacy costs) are then allocated to direct patient care costs and indirect cost centers using standard step-down procedures.

Direct patient care costs include nursing, ancillary services, and other routine services and are variable in terms of case-mix and volume. In apportioning these costs to DRGs, outpatient costs are prorated based on a ratio of charges. Nursing costs are apportioned based on the

inpatient days spent by patients of a DRG in different types of nursing units; that is, medical/surgical, pediatrics, etc. (In future rate setting, a nursing relative intensity measure methodology will be used.) Inpatient ancillary costs are apportioned to DRGs on the basis of the ratio of charges to charges applied to costs (RCCAC).

The direct patient care cost per DRG (with ancillary physicians' costs deducted and regional wage differences equalized) is averaged separately across all patients in teaching and in non-teaching hospitals to serve as an "incentive standard" for each group. A hospital's base payment rate for the DRG is a "blend" of its own direct patient care costs and its group incentive standard, according to a coefficient of variation formula. (As the variability of the cost within a DRG increases among peer hospitals, more of the individual hospital's costs and less of the incentive standard are included in the hospital's base rate for the DRG.)

The resulting figure (with ancillary physicians' costs added back and wage equalization reversed) is then adjusted by a hospital "economic factor" derived from fluctuations in a composite index of economic indicators approximating the inflation in hospital costs for the base year through the rate year. This becomes the rate year direct patient care cost for the DRG. It is multiplied by the hospital-projected, commission-approved patient volume expected during the rate year for the DRG and is summed with the other similarly calculated DRG costs to yield the reasonable patient care costs for inpatients. (Inpatients with lengths of stay above or below certain range limits called trim points are termed outliers. These patients have atypical resource consumption and will pay charges for actual services received instead of DRG-determined rates.)

Outpatient costs are categorized into seven groups: ambulatory surgery, same day psychiatry, renal home dialysis, private referred patients, emergency room services, clinics, and home health. With the exception of private referred patients, who pay service charge rates, each category's costs are divided by the number of visits to determine its unit direct cost as a base rate. These figures are inflated by the hospital economic factor and multiplied by the projected outpatient volumes for the rate year, to yield the reasonable direct patient care costs for outpatients.

Indirect or institutional costs include operating costs for managerial, educational, and facilities maintenance services. They are considered fixed and not subject to variation because of changes in case-mix or volume. The indirect costs of each hospital are divided by its direct patient care costs, resulting in an indirect to direct costs ratio. These ratios for participating hospitals are ranked separately for teaching and non-teaching institutions. The portion of any hospital's ratio in excess of 110 percent of the median ratio is applied to its indirect costs, and the result is excluded from the allowable cost base. The indirect costs that pass this screening process as inflated by the hospital economic factor become the reasonable indirect costs.

Reasonable direct patient care and indirect costs are combined with financial elements (uncompensated care, working capital needs, capital facilities allowance, personal health allowances, and payer differentials) to derive the rate year preliminary cost base (PCB).

To develop a hospital revenue budget from the PCB, reasonable direct patient care costs are reaggregated into revenue-producing centers. Reasonable indirect costs and other financial elements are added, and volume projections are applied to yield an estimated revenue budget. The hospital uses this budget to structure its charges and determine the amount that must be billed to patients in the different DRGs so that the revenue collected at the end of the rate year equals the PCB, adjusted for actual patient volume and case-mix.

At the end of the rate year, a final reconciliation will be derived from patients' uniform bills and audited hospital financial statements to determine differences between the revenue actually collected and the approved revenue budget, adjusted for actual volume and case-mix. Any over or under collection, plus interest, will be included in the next year's rates.

Hearings/Appeals:

SHARE System

After the rate (PAR) is established, the facility has the right to an informal meeting with the staff of the Department of Health to justify the addition of disallowed costs. Both the facility and third party payer have the right to a formal appeal before an administrative law judge (ALJ) under the State's administrative procedures act. The ALJ renders findings of fact and recommendations to the Commissioner of Health to establish the final administrative role (FAR). Further appeal from the PAR may be made to the Appellate Division of the New Jersey Superior Court.

S.446 Case Mix System

The hospital is notified of its schedule of rates and receives a complete rate package. Within 30 days, the hospital must: 1) accept the rates, which means waiving appeal rights except for the capital facilities allowance, 2) conditionally accept the rates, which allows the hospital the right to appeal certain specific items, or 3) not accept the rates. With respect to any appealed exception, the hospital forwards an appeal document, and the Department and the hospital conduct a detailed review. Based on the review and any additional documentation required, the State Commissioner of Health submits a report to the Commission. The hospital may petition the Commission regarding this report. The Commission may render a decision on the merit of the records to modify the rates, hold a hearing, or refer the appeal to a State ALJ.

Developmental Activities: While the New Jersey State Department of Health under its HCFA contract will be principally concerned with application of the S.446 Case-Mix System statewide, numerous refinements of the rate setting process are anticipated as experience is gained.

Pending Legislation: None
Contact for Additional Information:
Assistant Commissioner
Division of Health Planning and Resource Development
New Jersey State Department of Health
John Fitch Plaza
P.O. 1540
Trenton, New Jersey 08625

State: New York

Statute: Public Health Law Sections 2800 through 2807
Date: 1969 and amendments in subsequent years
Purpose: To promote hospital and health-oriented services of the highest quality and to ensure that they are efficiently provided and properly used
Responsible Agency: Department of Health

The Commissioner of the Department of Health certifies that proposed rates are reasonably related to the costs of delivering efficient health care services. Rates for Medicaid are certified to the Director of the Budget, rates for Blue Cross are certified to the Superintendent of Insurance, and rates for Worker's Compensation are certified to the chairperson of the Worker's Compensation Board. Rates for Medicaid are developed by the staff of the Department of Health under regulations approved by the State Hospital Review and Planning Council. Blue Cross rates are developed separately by Blue Cross plans using procedures approved by the Department of Health which are "not inconsistent" with the regulations passed by the Council. The Department of Health reviews the rates developed by the Blue Cross plans before certifying them.

Facilities Covered: Mandatory participation and compliance by all non-Federal hospitals
Payers Covered: Medicaid, Blue Cross, Worker's Compensation, no-fault insurance, and charge-based payers
Current Program: New York State is striving for a uniform system of reimbursement to include all payers. In New York, the Blue Cross, Worker's Compensation and Medicaid methodologies are now virtually identical. All three payers use a common grouping system, and all have length of stay and minimum utilization penalties. The Department of Health administers the Medicaid system for all hospitals in the State. Blue Cross rates are set by one of two basic systems: the downstate system (New York City metropolitan area) or the upstate system (remainder of the State). (Note: There are six separate upstate plans which vary slightly in their systems.) In addition, a charge control law was passed in 1978. This law, effective January 1979, established a panel of health economists who determine the inflation factor methodology for charges. Charges to charge-paying patients can only increase by the lower of the established inflation factor or the actual increase in costs. Appeals to the charge control limitation can be made to an Appeals Board for significant volume changes or a change in types of services.

For each system, hospitals are required to file a uniform cost report with the State and respective Blue Cross plan within 120 days of the close of the fiscal year. They must use the Uniform Financial Reporting System (UFR, USR), which includes both financial and statistical data. In addition, supplemental data must be filed for both Blue Cross and Medicaid, accounting for differences in coverage.

Medicaid System

The Medicaid formula establishes a *per diem* rate based on actual cost incurred in a base year. Base year costs are analyzed through inter-hospital group comparisons. There are currently two different grouping methodologies in New York State. The traditional grouping methodology, employed downstate, stratifies the universe of hospitals into groups of like hospitals according to psychometric weights. An innovative grouping methology referred to as "seed-cluster" grouping was introduced upstate beginning in 1980. Under this approach, a statistical method establishes each hospital as the center of its own group and gathers around that hospital all other facilities which are most similar, as measured by least distances. This method produces a group for every hospital and has the benefit of not excluding any hospitals from consideration in more than one group.

Routine costs are screened against an adjusted group average *per diem*, and ancillary costs are screened against an adjusted group average per discharge. Those costs in excess of the group average are disallowed. Next, an excessive length of stay penalty (equal to routine *per diem* times the number of excess days) is applied if appropriate. New York State's length of stay standard is hospital-specific, taking into account each hospital's unique case-mix. This is done with an age/diagnostic classification system, where a separate LOS standard is developed for each of the resulting 494 different types of patients.

Once the standards are developed, a unique overall standard is developed for each hospital by relating its case-mix to the broader standards (normalization). New York uses four separate sets of standards—upstate teaching, upstate non-teaching, downstate teaching, and downstate non-teaching. The standards for each set were determined by taking the hospitals in each category and averaging the lengths of stay for each type of patient. It should also be noted that a one day corridor is added to the length of stay standard calculated for a facility. Also, 10 percent of residents' and interns' salaries is automatically excluded. The addition of routine and ancillary cost less disallowances yields the base year costs.

The base year costs, exclusive of capital costs and historical cost depreciation (which are pass-through costs), are indexed forward to the prospective budget year. The inflation factor in New York, called a trend factor, comprises labor and non-labor inflation rates. Hospitals are grouped according to size, geographic location, and type. Each hospital then receives its group's specific wage inflation rate. This rate is derived from the weighted average of inflation rates for hospital and other wages. Under the charge control legislation of 1978, collective bargaining agreements must be considered in determining the wage

inflation rate. The second part of the trend factor, the non-labor rate, is computed in a similar manner, using appropriate inflation indices weighted by the percentage of total expenditures represented by each item.

Capital and depreciation costs are added to the inflation-adjusted base costs to establish the total allowable inpatient cost for the prospective year. This total inpatient cost is divided by patient days (adjusted for minimum occupancy levels by service) to determine the *per diem* rate. If the hospital's occupancy rate for a service is below the service's minimum occupancy level, expected patient days at the minimum occupancy level are substituted for actual days. Occupancy below minimum levels will lower the hospital's *per diem* rate. New York currently has a volume adjustment which is applied to Blue Cross, Medicaid, and Worker's Compensation rates of payment according to the same rules. Under the rules, capital costs are considered to be 100 percent fixed, and operating costs are considered to be 80 percent fixed and 20 percent variable.

Blue Cross System

The major difference between the Medicaid system and the Blue Cross system is in the screening of base year costs. The Blue Cross plans combine the routine, ancillary, and length of stay penalties into one penalty. This yields an overall group average cost per discharge ceiling. Upstate Blue Cross plans use 100 percent of average and downstate Blue Cross 102 percent of average as the ceiling.

The facility is at risk for any overexpenditure and may keep any profit resulting from underexpenditure. Each system allows for a retroactive adjustment for actual variance in the economic factors.

Hearings/Appeals: Hospitals have 120 days to file an appeal with the State, specifying why they believe their rate to be inadequate. The State then review the hospital's submission and makes a recommendation to the Commissioner of Health. If the facility is dissatisfied it may request a formal appeal before a State hearing officer. If still dissatisfied, recourse is to the courts.

Developmental Activities: Under HCFA Grant No. 18-P-90707/2-01, the New York State Office of Health Systems Management will develop and implement the necessary statistical and financial reporting systems to support a model health care financing data system. All hospitals in the State of New York will be required to adopt a uniform reporting system, a uniform billing set for all patients, and a uniform patient discharge abstract set for all patients that is linked to the uniform billing information. These source documents will be collected, computerized, and merged into master data files to establish a uniform, comprehensive, and centralized source for hospital statistical, medical, and financial information. Output reports will be developed from these files for effective management at the institutional level and for planning and rate setting needs at the statewide level. The project also involves developmental efforts for measuring case-mix complexity and for designing reimbursement methodologies based on per admission payment adjusted for hospital caseload complexities.

Pending Legislation: None
Contact for Additional Information:
Director
Office of Health Systems Management
Tower Building
Empire State Plaza
Albany, New York 12237

State: Oregon

Statute: ORS Chapter 442, Sections 400 through 450
Date: July 1977
Purpose: To achieve equal access to quality health care at a reasonable cost
Responsible Agency: State Health Planning and Development Agency

The Oregon State Health Planning and Development Agency (SHPDA) is responsible for reviewing and commenting on existing and proposed hospital rates. The agency has no enforcement powers, but it reviews the rates, determines their reasonableness, and publicizes those deemed unreasonable. The director is appointed by and serves at the pleasure of the Governor.

The Oregon Statewide Health Coordinating Council (SHCC) serves as an advisory council to the agency on general policymaking issues; however, it is not involved in rate review. The SHPDA has created a special technical advisory committee for rate review matters. The Cost Containment Advisory Committee is composed of representatives of hospitals, physicians, payers, consumers, and a public agency.
Facilities Covered: Mandatory participation but voluntary compliance by all non-Federal hospitals
Payers Covered: Charge-based payers (including Blue Cross)
Current Program: Hospitals submit budget data to the State agency for any proposed increases 30 days prior to the beginning of the effective date. Operating and fiscal data are reported monthly via American Hospital Association's Monitrend system. There are no standard accounting forms, but the monthly reporting is on the standard Monitrend form for computer input. Financial sheets are also filed with the State agency after audits are completed.

The State reviews the budget (capital and operating) and Monitrend monthly reports to determine the reasonableness of the budgeted amount. Staff review total and cost center amounts, considering such factors as inflation, volume changes, and the reasonableness of the rates being charged. They make recommendations to the agency director as to the reasonableness of the budget and charges.

There is no provision for retroactive adjustments unless the statutory 30-day advance notice of price increases has not been given. A facility may give notice of a change of rates at any time during the year.
Hearings/Appeals: Since compliance is voluntary, there is no mechanism for appeal.

Developmental Activities: None
Pending Legislation: None
Contact for Additional Information:
Manager
Health Economics and Resource Development Section
State Health Planning and Development Agency
211 Front Street, N.E., Suite 108
Salem, Oregon 97310

State: Rhode Island

Statute: Chapter 208, Title 27 of the General Laws
Date: July 1971
Purpose: To make the State, hospitals, and hospital service corporations parties to budget negotiations held to determine prospective payment rates for hospital costs
Responsible Agencies: Blue Cross, State Budget Office

The staff of Blue Cross, the State Budget Office, and the Hospital Association of Rhode Island set a Maxicap, the maximum percentage increase in total hospital expenditures allowed in the State during the coming year. Subsequently, the staffs of Blue Cross and the State Budget Office (jointly referred to as the third parties) and the hospitals conduct hospital budget negotiations. The State has not issued specific regulations defining the rate review process. Instead, the hospitals, Blue Cross, and State Budget Office establish the process in a contractual agreement.
Facilities Covered: Mandatory participation and compliance by all non-Federal hospitals
Payers Covered: Blue Cross, Medicaid
Current Program: A Maxicap is set annually by negotiation. Hospitals subsequently submit cost data on their current and prospective budget years using a uniform reporting system. The budget review process focuses on the incremental changes from current to prospective years. These changes are reviewed on both a global and cost center level. Hospitals are grouped, but inter-hospital comparisons are limited. In assessing the increment from the base year, the Blue Cross staff consider inflation, volume changes, and the provision of new and expanded services. A statewide medical program review and priority process are used to determine the appropriateness of new or expanded services.

After total operating expenses have been negotiated, the hospital establishes a schedule of charges. Blue Cross and the State Budget Office review this schedule for accuracy of revenue calculations. The schedule of charges is then used to establish separate rates for Blue Cross and Medicaid by adjusting for cost and benefit differences.
Hearings/Appeals: If the third parties and a hospital cannot reach agreement, negotiations end and a two-phase review process begins. First, both sides are brought together for formal mediation. This process differs from normal negotiations in that it involves members of the hospital's governing board and officials of third parties. If mediation does

not result in agreement, unresolved issues go before an independent arbitrator for binding arbitration. The arbitrator must choose one of the two positions and is not free to consider any modifications of positions which might have occurred during mediation.
Developmental Activities: None
Pending Legislation: None
Contact for Additional Information:
Director of Reimbursement
Blue Cross of Rhode Island
444 Westminster Mall
Providence, Rhode Island 02901

Budget Program and Management Specialist
State Budget Office
Room 100
State House
Providence, Rhode Island 02903

State: Virginia

Statute: Code of Virginia, Title 9, Chapter 24
Date: April 1978
Purpose: To establish a uniform system of financial reporting and to publish and disseminate information relating to health care institutions' costs and charges; also to initiate reviews or investigate as necessary to assure all purchasers of health care services that the aggregate charges are reasonably related to reasonable aggregate costs and that charges are equitable
Responsible Agency: Virginia Health Services Cost Review Commission
The Virginia Health Services Cost Review Commission is an 11-member independent commission appointed by the Governor. It consists of five consumers, three hospital representatives, one representative of a prepaid hospital service plan, one representative of a commercial insurer, and the Commissioner of Health. The Commission contracts with a voluntary non-profit rate review organization (Cost Analysis Service) to perform technical analysis of hospitals' budgets, proposed rates, and historical financial data.
Facilities Covered: Mandatory participation but voluntary compliance by all non-Federal hospitals
Payers Covered: Charge-based payers
Current Program: Each hospital is required to submit an annual budget consisting of revenues, costs and volumes at least two months prior to the beginning of the fiscal year. Each hospital will also submit an annual summary report no later than 120 days after the end of the hospital's fiscal year. The report will be submitted on a Year End Summary Financial and Statistical Data Form, together with a copy of an audited financial statement/audit report and Schedule B-1 (Statistical Page) of the Medicare Cost Report. The Commission uses these data for future budget review purposes and for a historical data program.

The hospital budgeted rate structure is to be based on Commission guidelines which define the elements of the hospital's total financial requirements. The elements of financial requirements are:

1) Current operating requirements, consisting of patient care costs, patients who do not pay, and educational and research costs
2) Operating margin, consisting of working capital and capital requirements for major renovations, repairs, plant and equipment replacement, and expansion and new technology
3) Taxes and return on equity (for investor-owned institutions).

A major concept of the rate review process is that only exceptional costs or revenues will be reviewed and that judgment (as opposed to a step-by-step process) will be used to assess reasonableness. Screens have been developed to highlight the unusual cases, but they will not be applied as ceilings. Thus a screen is a benchmark or standard value for some element of hospital cost against which hospital budgeted values are compared to determine their reasonableness.

The Commission has contracted with Cost Analysis Services (CAS) to perform the technical review functions. CAS reviews budgets, proposed rates, and/or historical financial data by doing the following:

1) Reviewing hospital-wide and departmental indicators (overall measures of activity) to gain a general understanding of the hospital's operations
2) Reviewing the current operating needs by screening departmental direct costs and productivity and hospital-wide costs
3) Reviewing capital needs by evaluating plant capital needs, working capital needs, and return on investment needs; performing the overall capital needs test based on percent return on assets
4) Allocating all hospital-wide costs and all general service (indirect) costs into revenue producing departments using the single stepdown apportionment method
5) Allocating all capital needs to revenue producing departments
6) Reviewing revenue projections
7) Analyzing relationship of charges to cost
8) Preparing a report to the Commission.

The Commission reviews the analysis and comments at scheduled meetings, after which the summaries and comments become a matter of public record and may be published and disseminated. Any hospital subject to Commission findings is given an opportunity to be heard before the Commission. There is no appeals process since compliance with Commission recommendations is voluntary.

Development Activities: None

Pending Legislation: None

Contact for Additional Information:

Virginia Health Service Cost Review Commission
Room 115
2015 Staples Mill Road
Richmond, Virginia 23230

State: Washington

Statute: RCW Title 70, Chapter 39, (Chapter 5 Laws of 1973, First Ex. Sess.)
Date: March 1973
Purpose: To establish a hospital commission with authority over financial disclosure, budget, prospective rate review, and other related matters, which will assure all purchasers of hospital health care services that total hospital costs are reasonably related to total services, that hospital rates are reasonably related to aggregate costs, and that such rates are set equitably among all purchasers of these services
Responsible Agency: Washington State Hospital Commission

The Washington State Hospital Commission is a five member independent commission, appointed by the Governor and confirmed by the Senate. It comprises representatives of labor, business, and hospitals, as well as consumers. No more than two members may have a fiduciary duty to a health facility or agency or a financial interest in rendering health services. Rules and regulations for rate setting are issued under the direct authority of the Commission. The Commission is assisted in its activities by an 11 member technical advisory committee also appointed by the Governor. The advisory committee consults and makes recommendations to the Commission on matters of policy, rules, and regulations, as requested by the Commission.

The rate review is performed by a full-time professional staff, headed by an executive director appointed by the Commission. Rates are issued after review under the authority of the full Commission.
Facilities Covered: Mandatory participation and compliance by all non-Federal hospitals
Payers Covered: All purchasers of hospital services (Medicare, Medicaid, State Department of Labor and Industries, and Blue Cross on an experimental basis)
Current Program: At least 60 days before its fiscal year, each hospital is required to submit detailed information on its costs, statistics, and charges for its past, current, and budgeted fiscal years, using a uniform accounting and reporting system. These data are used to develop screens for budget review.

The emphasis of the budget review process is on identifying high cost operations and disallowing those costs exceeding certain screens. The initial step is an examiniation of the budget to determine any significant changes, such as new beds or services, which could affect the budget. Next, a volume analysis is performed to determine if the hospital's volume projections are reasonable.

The hospital's operating budget is then screened twice. Hospitals are clustered into peer groupings which are developed after considering: size, teaching level, case mix, geographic location, and other variables. The operating budget is first reviewed on a global level using primary screens. Primary screening consists of reviewing budgeted total operating expenses, cost per patient day, cost per admission, and the percentage change from base to budget year for each of those items. In order to pass

a screen, the facility must be at or below the 70th percentile for its peer group. If the facility passes all screens, its proposed operating expenses are approved. If it fails any one screen, a second screening process is initiated. The secondary screening consists of a review of each cost center to measure intensity, input prices, and productivity. To pass a secondary screen, the facility must be at or below the 70th percentile for its peer group. If a cost center passes a screen, no further review is required. If it fails a screen, the staff perfom a detailed analysis of that cost center by classifying expenses and considering inflation, changes in volume, and uncontrollable cost.

Deductions from revenues are allowable costs. These deductions are 1) cost associated with contractual allowances from Blue Cross, Medicare, and Medicaid and 2) charity and bad debt.

The Planned Capital and Service Component, which is not subject to peer group review, is added to the approved operating budget amount. It consists of the following: 1) net increases in working capital, 2) prior debt commitments, and 3) expansion and acquisition of new equipment. This component is reviewed by staff for appropriateness and adequacy, considering the facilities' overall financial needs.

A revenue to expense ratio analysis is then performed on the proposed rates to satisfy the statutory requirement that rates be reasonably related to costs. After consideration of all of the above, the Commission recommends the amount of total rate setting revenue which will allow the facility to meet its financial needs. The facility uses the approved rates in establishing its list of charges. The amount of incentive or risk and the method, if any, of retrospective adjustments vary depending upon which of three groupings a hospital falls into under a current experiment (see Developmental Activities, below).

Hearing/Appeals: The Commission must submit its findings to the hospital at least 15 days prior to an informal hearing. At this hearing the facility may present evidence which it feels justifies adjustments beyond those recommended by the Commission.

If a hospital is dissatisfied with the decision of the Commission after the informal hearing, it may appeal to the Commission for a formal hearing of record. This formal hearing is conducted by either a member of the Commission or an independent hearing officer, at the Commission's option. If the facility is dissatisfied with the results of the formal hearing, it has recourse to the courts.

Developmental Activities: The Commission has been setting payment rates for Medicare, Medicaid, Blue Cross, and the Department of Labor and Industries as a demonstration program under HCFA Contract No. 600-76-0170. All hospitals have been assigned on a random basis to one of three payment groups. All hospitals go through the existing budget review system to determine their total revenue needs; the methods of payment and resulting incentives, however, differ substantially.

The Commission projects the total charges to be billed to each payer during the prospective year. It then applies a differential pricing mechanism to allocate certain costs to specific payers more equitably. The result is total allowable revenue apportioned to each payer category. For the first group of hospitals, each participating payer pays the

apportioned amount. The participating payers reimburse bimonthly based on the percentage of the hospital's budget each third-party payer contributed during the previous year, with quarterly adjustments for changes in payer mix. There are no cost settlements or retroactive volume adjustments. However, the hospital can request adjustments during the year for unanticipated changes in inflation rates, labor costs, or other costs. If a facility spends more than the approved revenue, it is at risk for the excess cost. If it spends less than anticipated, it keeps the excess revenue.

The second group of hospitals is reimbursed on a percentage-of-charge basis by each participating payer. The specific percentage for each payer is determined by the Commission, based on the total amount of charges needed to generate the total allowable revenue apportioned to each payer.

The third group of hospitals continues under the normal review system whereby a hospital sets its charges to generate the Commission-approved revenue. However, the charges apply only to private pay and commercial insurers, while Blue Cross, Medicaid, and Medicare reimburse retrospectively based on costs.

Hospitals in all reimbursement groups are subject to a conformance review. This review uses audited financial reports plus revenue information. After adjustments for volume and payer mix, any revenue in excess of the approved financial needs is applied against the next year's revenue.

This three-cell reimbursement experiment will assess the difference in expenditures resulting from the alternate methods of reimbursement. In addition, the Commission is further developing its case mix methodology, conducting a study of fixed and variable costs, refining the screening techniques used in the budget review process, and re-examining the cluster analysis techniques used in its grouping methodology.

Pending Legislation: None

Contact for Additional Information:

Executive Director
Washington State Hospital Commission
206 Evergreen Plaza Building
711 South Capitol Way, FJ-21
Olympia, WA 98504

State: West Virginia

Statute: Chapter 16, Article 5-F of the West Virginia Code
Date: 1979
Purpose: To provide for public disclosure of hospital financial information and to initiate reviews to determine whether charges are economically justified
Responsible Agency: Department of Health

In 1979, the West Virginia legislature enacted the Health Care Facilities Financial Disclosure Law, which requires hospitals to file financial reports

with the Director of Health and publish a financial statement in a local newspaper. The Director of Health may determine whether the rates charged by a hospital are economically justified.
Facilities Covered: All hospitals over 15 beds
Current Program: The West Virginia program is in the early development stage. By statute, within 120 days of the end of its fiscal year each hospital must file the required reports with the Director of Health and publish, as a legal advertisement in a local newspaper, an annual report prepared by the facility's auditor or an independent public accountant. The report must contain a complete statement of facility's assets and liabilities income and expenses, and profit or loss, as well as a statement of ownership for persons owning more than 5 percent of the capital stock. The complete report is made available at the Department of Health as public information.

The reports to be filed by each covered facility include: (1) a statement of services available and services rendered; (2) a statement of the facility's total financial needs and resources available to meet those needs, that is, a budget; (3) a schedule of its then current rates; (4) a copy of the cost reports filed with the Health Care Financing Administration and the State Medical Agency; and (5) statements of all charges, fees, or salaries paid in excess of $55,000 and all charges, fees, or other sums in excess of $55,000 collected by the covered facility on behalf of any other person, firm, or partnership.

There is currently no budget review process; however, one is contemplated. The Director of Health may carry out analyses and studies related to health care costs and the financial status of any hospital and make determinations as to whether the rates charged by a hospital are economically justified.

Compliance with the finding of the agency is voluntary; there is no appeal mechanism.
Developmental Activity: None
Pending Legislation: None
Contact for Additional Information
Director Health Planning and Evaluation
West Virginia Department of Health
1800 Washington Street
Charleston, West Virginia 23505

State: Wisconsin

Statute: Section 49.45, Section 146.60 Wisconsin Statute; Chapter 39, Wisconsin Laws of 1975, Chapter 224 Wisconsin Laws of 1976
Date: Although the enabling legislation was passed in 1975, the program did not become operational until 1977. The participation of both Blue Cross of Wisconsin and the Wisconsin Hospital Association in a hospital rate setting program raised the question of whether the program violated antitrust laws. That issue was resolved by the Anti-Trust Division of the U.S. Department of Justice when it issued clearance for the program in 1977.

Purpose: To allow reimbursement of hospital costs to be determined prospectively, in order to provide incentives for cost containment
Responsible Agencies: Wisconsin Hospital Rate Review Committee

By statute, prospective rates may be established directly by the Department of Health and Social Services or through a mutual agreement with the Wisconsin Hospital Association and Blue Cross of Wisconsin. The State has chosen the latter approach.

Under the three party agreement, an independent Rate Review Committee was established. It is composed of 20 members; six appointed by the Governor, six appointed by the hospital association; six appointed by Blue Cross, and two appointed jointly by the State and the hospital association. Authority to decide on the reasonableness of rates rests with the Rate Review Committee. Blue Cross performs the actual budget analysis and the Department of Health and Social Services provides technical support for developing methodology.
Facilities Covered: Mandatory participation and compliance by all non-Federal hospitals
Payers Covered: All payers except Medicare
Current Program: The rate review process begins when a hospital submits a request for a rate increase. The request must be submitted 60 days prior to the proposed implementation data. Data supporting the need for the increase must be submitted no later than 45 days prior to the implementation date. Hospitals are limited to one rate increase per fiscal year, unless extenuating circumstances exist. They are encouraged to time their request to coincide with the beginning of their fiscal years.

Supporting data include, but are not limited to, the following: budgets (operating and capital, current and/or prospective), interim financial statements, audited and certified annual financial statements, Title XVIII and XIX cost reports, and stardardized reporting forms. A uniform accounting and reporting system is not used. Instead, Blue Cross staff transfer the hospital data to their own format for internal analysis.

The data analysis consists of two comparisons. First and most important, the hospital's current request is compared with its prior experience. Second, the hospital's current request is compared with the experience of a group of similar hospitals. The hospital groups used in the analysis are based on geographic location, size, and teaching activity. The items that are analyzed in both comparisons are: percent of occupancy, length of stay, employees per patient day, average salary per employee, days of revenue in accounts receivable, days of cost in inventory, revenue *per diem*, financial requirements *per diem*, total revenue *per diem*, operating expenses *per diem*, charge per admission, and *per diem* cost of research and educational programs. Deviations determined during the comparisons do not necessarily result in an adverse reaction. The facility has the opportunity to justify any above average costs.

Based on their analysis, the staff present the Rate Review Committee with a recommendation to approve, disapprove, modify, or defer the requested rate increase. If a hospital disagrees with the recommendation of the staff, it may present its position before the Committee in person. If the Committee decides to modify or disapprove, it must specify which

elements in the hospital's budget are considered unreasonable. The amount of reduction in each element and how it applies to each payer must also be specified by the Committee.

Medicaid payments are computed using the Committee-approved budget. The hospitals' total budgeted expenses by department, after rate review, are adjusted to allowable budgeted expenses in accordance with Medicare reimbursement principles in effect at the time of budget submission. The adjusted budget is then apportioned to Medicaid based on the department's percentage of Medicaid utilization. The total Medicaid budget is then divided by the budgeted Medicaid days to arrive at the Medicaid *per diem*. No retroactive adjustment is made unless there are extenuating circumstances.

Hearings/Appeals: A hospital, the Wisconsin Hospital Association, Blue Cross of Wisconsin, or the State of Wisconsin may appeal a decision of the Rate Review Committee. Appeals must be brought before a seven-member board, selected from the total Appeals Board membership of 21, within 10 calendar days of the Committee's decision. The board considers cases on alleged violation of due process and questions of fact. The appealing party has the right to be present at the appeal and to be represented by legal counsel. The board can uphold the Committee's decision or reverse it and require the Committee to redetermine the hospital's rate. The board's decision is final.

Developmental Activities: As part of the agreement establishing the Rate Review Committee, a Standards Development Committee was created. Staff for the Committee are determined by the State Department of Health and Social Services. It is the Committee's responsibility to review the hospital peer groups and modify the groups as required to improve the comparative analysis of costs. The Committee is also responsible for developing improved standards of hospital performance to be used by the Rate Review Committee in detemining the reasonableness of hospital rates.

Pending Legislation: None

Contact for Additional Information:

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Bureau of Health Care Financing
Department of Health and Social Services
One West Wilson Street
Room 211
Madison, Wisconsin 53702

Health Care Financing Abstracts of State Legislated Hospital Cost Containment Programs

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